radiation. We are reporting this case because of this rare histology and the uncommon presentation of the precursor lesion at the same time. DAP is regarded as an aggressive disease compared with the AAP with a worse overall and prostate specific survival. Commonly, when DAP is found, is already at more advanced stage, with large tumor volumes, high incidence of extra-prostatic extension and lymph nodes metastasis. DAP is arbitrarily assigned an 8 Gleason score (4+4), which describes the behavior of theses tumors. The intraductal component represents the malignant lumen-spanning proliferation within prostatic ducts and acini, as in our case, these lesions are found almost exclusively in close proximity to invasive cancer. In summary while most DAP diagnosed is associated with concomitant AAP with adverse pathology features, a highly selected subset could be found as pure DAP. In these cases is recommended a clinical management and therapy similar to those for AAP of similar Gleason and stage, considering androgen-deprivation and adjuvant radiation treatment.

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A new dietary and laxative protocol in prostate cancer radiotherapy

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Background. The position of the PTV in prostate cancer radiotherapy is affected by rectal distension. A distended rectum at the planning CT scan reduces disease control (1, 2). Dietary and laxative protocols significantly reduce rectum distension at the CT planning scan (3). We tried to work with foreign dietary protocols but they had not result in our environment.
Objectives. To study the feasibility of the new protocol and to compare rectal distension and rectal toxicity in patients before and after the implementation of the protocol.
Methods. We designed a "Mediterranean adaptation" of the Dutch antiflatulent diet published by Smitsmans et al. (3). CT planning scans before the implementation of protocol were compared against scans of patients subject to the new protocol. Rectal distension was assessed according to De Crevosier et al. (1). Rectal toxicity was assessed according to RTOG scoring criteria.
Results. Eighty-seven no-protocol patients were compared against 92 protocol patients. The rectal expansion were lower among the protocol patients with an average CSA of 7.39 ($\pm$0.54) cm^2 vs. 9.29 ($\pm$0.92) cm^2; $\alpha = 0.05$, $p = 0.0027$. On the other hand, grade 3 acute rectal toxicity (rectal bleeding during radiotherapy) was significantly lower among the protocol patients (3% vs. 13%).
Conclusions. This protocol is feasible in our population and reduces rectum distension at the CT planning scan. In addition rectal bleeding during radiotherapy is significantly lower in protocol patients. 1—De Crevoisier et al., IJROBP, 62: 965–973, 2005. 2—Heemsbergen et al., IJROBP, 67: 1418–1424, 2007. 3—Smitsmans et al., IJROBP, 71: 1279–1286, 2008.

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Abiraterone acetate in metastatic prostate cancer: Experience in our institution

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Introduction. Abiraterone acetate (AA), a potent oral CYP17A1 inhibitor is approved for treatment of metastatic castration-resistant prostate cancer (MCRPC) with a survival advantage of 4.9 months.
Purpose. To evaluate the experience in our institution of the AA treatment in MCRPC.
Material and methods. PSA, radiological and clinical responses are retrospectively analysed in patients treated with AA in our institution.
Results. 12MCRPC received AA across 2012. Median age is 67 (range: 58–83). 6 post-docetaxel, 1 post-estramustine and 4 had not received chemotherapy before starting AA. 3 patients obtained more than 50% of their PSA levels response after the beginning of AA, 2 after the first 3 months and 1 after the 6 months. 1 obtained a 25% PSA levels response after the 6 first months. 3 obtained a PSA level stabilization, 2 in the first 3 months, and 1 in the next 6 months. AA was interrupted in 6 patients, 3 because of a clinical and PSA progression, and 3 because of toxicity associated with AA. 5 patients are still on treatment with AA; 3 of these underwent a PSA level progression, but none of them experimented a clinical or radiological progression and maintain asymtomatic.
Conclusions. AA is a well tolerated treatment. Any patient suffered grade 3–4 toxicity. The treatment in metastatic prostate cancer seems to be very heterogeneous. Consensus about treatment in MCRPC patients should be achieved.

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Abiraterone in the management of elderly patients with castration-resistant prostate cancer. A case report

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Introduction. Metastatic castration-resistant prostate adenocarcinoma is defined by disease progression and/or PSA rise with testosterone levels less than 50 ng/dl. Abiraterone acetate inhibits androgen synthesis in all synthesis sources: testicles, adrenal

glands and tumor cells. Negligible androgen levels prevent stimulation of the intracellular receptor in the tumor cell, reducing PSA synthesis and growth factors.
Objectives. To demonstrate the therapeutic benefits and tolerance to abiraterone in elderly patients with metastatic castration-resistant prostate cancer.
Methods. 82 year old man, diagnosed with prostate adenocarcinoma in 2005 (75 year old), PSA 23, Gleason 6, T2b. Received complete androgen deprivation therapy alone (anti-androgen and GnRH agonist), follow-up examination showed PSA 0,04 decline in 2006, then progression to PSA 19,4 and bone scan suggestive of pelvic bone metastasis (2011). Discontinued treatment with anti-androgen. PSA rise to 43.74 in January 2012, 10 mg/24h prednisone prescribed. Follow-up showed PSA rise to 61 and alkaline phosphatase 300 in August 2012. Bone scan suggested metastasis in iliac and sacrum bone. Patient refers mild pain in rest and moderate pain while moving, no other symptoms associated. Karnosfky 95%, the CT extension study showed large bone metastatic spread and no visceral or lymph node involvement. Follow-up showed PSA 140, alkaline phosphatase 501, testosterone level less than 3 ng/dl in October 2012. Abiraterone acetate 1000 mg daily and prednisone 5 mg BID prescribed. Zoledronic acid 4 mg iv/28 days and calcium and vitamin D oral. Pain management with oxycodone–naloxone 20/10/12h and ibuprofen 600 mg/12h.
Results. Follow-up showed decline of PSA 27, alkaline phosphatase 300 and pain control improvement with no effect on blood test results including liver function (normal hepatic enzymes level) in February 2013 (4 months after treatment start).
Conclusions. Abiraterone demonstrates its feasibility as therapeutic choice for elderly patients due to good tolerance.

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Acute toxicity after combined HDR-BT and EBRT for prostate cancer

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Introduction. Clinical evidences support dose escalation radiotherapy for unfavorable prostate cancer (PCa). To achieve it, we combine Ir-192 High Dose Rate Brachytherapy (HDR-BT) with External Beam Radiotherapy (EBRT).
Purpose. Evaluation of acute urinary and intestinal toxicity during the following 6 months after treatment. Since almost all patients were under androgen deprivation therapy (ATD), sexual toxicity has not been analyzed.
Methods. Between August 2010 and May 2012, 67 patients with intermediate/high risk PCa were treated. Median age: 75 (62–82). Median follow-up: 14 months (6–29). Five patients had previous TURP and 3 had previous adenomectomy. EBRT administration was 200 cGy/fraction, 5/week. Median needles used for HDR-BT procedure was 18 (12–27). If seminal vesicles involvement (21 patients), a single fraction of 9–9.5Gy HDR-BT plus 60 Gy EBRT to pelvis and/or prostate-vesicles, was administrated. When seminal vesicles were not infiltrated (46 patients), a single fraction of 15 Gy HDR-BT plus 46 Gy EBRT to pelvis or prostate-vesicles. Sixty-one patients included ATD for 6 months in intermediate (24 patients) and 12–36 months in high risk PCa (37 patients). Toxicity evaluated following RTOG/EORTC criteria.
Results. After one month: 18 patients (26.8%) presented urinary toxicity; 16 G1 cases (dysuria and/or urgency), 1 G2 case (nocturia) and 1 G4 case (complete urinary retention). Three patients presented intestinal G1 toxicity (diarrhea and/or mild bleeding). After three months: 17 patients (25.3%) presented urinary toxicity; 13 G1 cases, 3 G2 cases and only one G4. Four G1 intestinal toxicity cases were observed. After six months: 17 patients (25.3%) presented urinary toxicity; 10 G1 cases, 6 G2 cases, and 1 G4 case. Only one patient presented G1 intestinal toxicity.
Conclusion. We found acceptable acute toxicity results. Main symptoms were dysuria and nocturia, most of them Grade 1. Only three urinary G4 cases observed along the analyzed period. Intestinal toxicity cases were few and mild.

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Acute toxicity in hypofractionated radiotherapy for prostate cancer

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Introduction. Recent publications have indicated that the α/β ratio for prostate carcinoma is much lower than previously established, suggesting that these tumours are much more sensitive to the dose administered per fraction. We do not know if the hypofractionated treatment provides clinical benefit in the treatment of prostate tumours.
Purpose. Assessment of the acute toxicity in patients diagnosed with prostate carcinoma and treated with hypofractionated radiotherapy.
Methods and material. Between January 2012 and May 2012, 78 men were treated at the Hospitalary Radiophysics Unit of the Hospital Complex of Jaén with ages comprised between 46 and 78 years old (average 68.3 years old), KPS 90-100%. They were diagnosed with prostate adenocarcinoma, PSA between 4 and 188 ngr/ml (average 16.39), Gleason 6 (56.5%) – 7 (23%) – 8 (9%) – 9 (5%) –others (6.5%), clinical stage T1c (65.4%), T2 (19.2%), T3 (15.4%). 78% of the cases were treated with androgen deprivation.